

This area for ASBP date stamp

Arizona State Board of Pharmacy

4425 W. Olive, Suite 140, Glendale, AZ 85302-3844
623-463-ASBP(2727), FAX: 623-934-0583
www.pharmacy.state.az.us

APPLICATION FOR COMPRESSED MEDICAL GAS PERMIT (Call Board Office for Fee Information)

Please Check Appropriate Type of Operation: Distributor/Repackager _____ Supplier _____

1. Business name: _____

2. Address: _____
Street and Number City State Zip

3. Phone: _____ FAX: _____ E-mail _____

4. Mailing address if different: _____
Street and Number City State Zip

5. Name of owner(s): _____ Phone: _____ FAX: _____
If corporation or partnership, attach a list officers or partners on a separate sheet, including name, title and address.

6. Date business started/opening: _____

7. Type of business (example: home health, medical equipment, welding, oxygen supply, etc.):

8. This application submitted because of change in ownership? No ____ Yes ____ If yes; give former owner's name, AZ permit number, and permit name (if different) _____

9. Other trade or business names used: _____

10. Have you conducted a similar business in any other jurisdiction?
No ____ Yes ____ If yes, state under what names, locations and permit number:

11. Has the owner, or any corporate officer or active partner ever been convicted of an offense involving moral turpitude, a felony offense, or any drug-related offense or has any currently pending felony or drug-related charges, and is so indicate charge, conviction date, jurisdiction, and location:

12. Has the owner, any corporate officer or active partner ever been denied a similar license/permit in this state or any other jurisdiction? No ____ Yes ____ If yes, indicate where and when:

13. FACILITIES LOCATED IN ARIZONA the following is required:

Zoning. Include documentation of compliance with local zoning laws.

14. FACILITIES LOCATED OUTSIDE OF ARIZONA: Attach a photo copy of license/permit issued by State of domicile.

15. Name of manager or responsible person: _____ Emergency phone: _____

Home address: _____
Street and Number City State Zip

On separate document: Resume indicating educational or experiential qualifications related to compressed medical gas operations.

To the best of my knowledge and belief the foregoing application is true and current in all respects.

Signature of Owner or Owner's Representative

Title

Date